COLORADO CENTER FOR
Primary Care
Innovation

Person-Centered Goal-Oriented Care

An Implementation Guide for Clinicians

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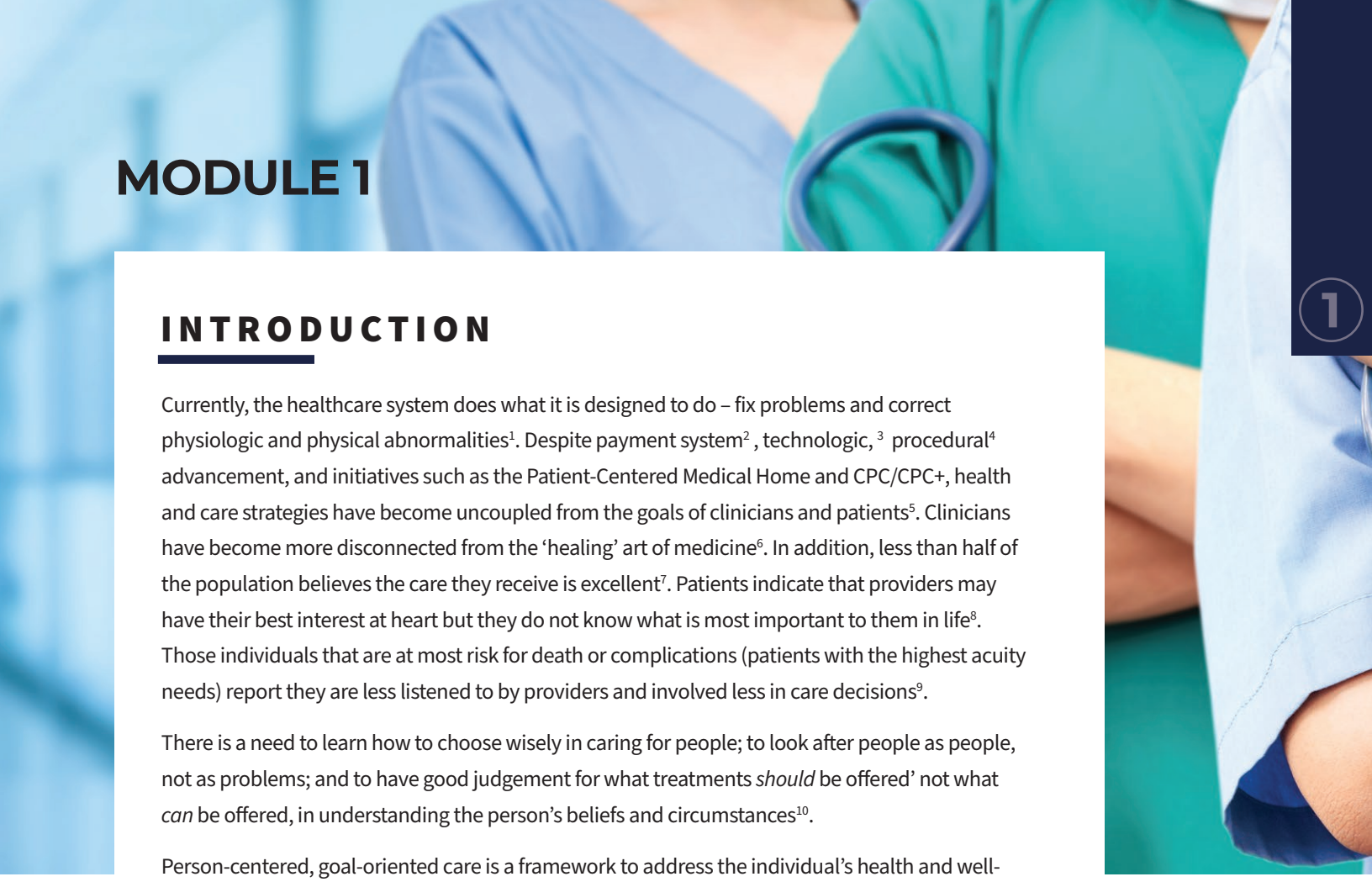

MODULE 1

INTRODUCTION

Currently, the healthcare system does what it is designed to do – fix problems and correct physiologic and physical abnormalities[1]. Despite payment system[2] , technologic, [3] procedural[4] advancement, and initiatives such as the Patient-Centered Medical Home and CPC/CPC+, health and care strategies have become uncoupled from the goals of clinicians and patients[5]. Clinicians have become more disconnected from the 'healing' art of medicine[6]. In addition, less than half of the population believes the care they receive is excellent[7]. Patients indicate that providers may have their best interest at heart but they do not know what is most important to them in life[8]. Those individuals that are at most risk for death or complications (patients with the highest acuity needs) report they are less listened to by providers and involved less in care decisions[9].

There is a need to learn how to choose wisely in caring for people; to look after people as people, not as problems; and to have good judgement for what treatments *should* be offered' not what *can* be offered, in understanding the person's beliefs and circumstances[10].

Person-centered, goal-oriented care is a framework to address the individual's health and well-being goals while preserving the traditional Values of Medicine – respect for autonomy of the patient, beneficence, non-maleficence, and justice[11].

To date, there has yet to be a series of Early Lessons Learned and Best Practices in Family Medicine to support transformational change towards redesigning the system for a new outcome – the patient's life and health goals.

This guide offers ideas and suggestions to implement this transformational change and is a companion to Goal-Oriented Medical Care: *Helping Patients Achieve Their Personal Health Goals* by James Mold, MD, MPH. that serves as its textbook and prerequisite reading.

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[3]Moving from Problem-Focused to Goal-Oriented Health Records. Ann Fam Med 2018;16:155-159. https://doi.org/10.1370/afm.2180.

[7]RWJF 2017

[8]Westminster Medical Clinic patient survey 2019.

[10]T.F. Fox, Lancet; April 2, 1960

[11]Beauchamp T, Childress J. *Principles of Biomedical Ethics*, 7th Edition. New York: Oxford University Press, 2013

Theoretical Underpinning

Goal-oriented care is rooted in Self-Determination Theory (Deci and Ryan) [Link] which posits that human beings have three major psychological needs, connection, autonomy, and competence. The processes involved in goal-oriented care support all three.

This Implementation Guide is for:

Practices and practice facilitators and coaches who want to adopt and implement person-centered, goal-oriented (PC-GOC) principles and methods. While information about PC-GOC is sprinkled throughout the Modules, the Guide will be most helpful to those who have a solid understanding of PC-GOC from journal articles, books, and/or workshops and presentations. This Guide was tested and modified by a group of diverse practices in a research network that imbedded their learnings on how to make this transformation successful. Your practice may make change differently. Let your culture and circumstances modify and adapt this Guide to fit your practice.

DEFINITIONS

Life: A journey filled with both challenges and opportunities for joy, fulfillment, and personal growth and development.

Health: The ability to derive maximum benefit from life's journey.

Goal: A desired outcome about which it makes little sense to ask, "… so that?" or "in order to?". There are 4 categories of health-relevant goals:

1. **Prevention of premature death and disability;**

   Example: If I take a statin (strategy), it will reduce my risk of a heart attack from x% to y% (objective), so that I can live 4 months longer and see my grandson graduate from college (goal).

2. **Maximization of current quality of life;**

   Example: If I lose 30 lbs. (objective), I will be able to get down on the floor and play with my grandkids (goal).

3. **Optimization of personal growth and development;**

   Example: Learning mindfulness (strategy) will increase my ability to deal with stresses at work (objective) so that I will be able to continue to learn and grow professionally (goal).

4. **Achieving a good death.**

   Example: Discussing my end-of-life wishes with my wife (strategy) will prepare her for decisions that she may need to make on my behalf (objective) so that I can experience a good death as I define it (goal).

Value: An underlying reason a person wants to pursue a particular goal.

Priority: an ordering of goals based upon importance (or some other criterion).

Objective: A (usually measurable) step toward goal achievement.

Strategy: A method used to reach an objective and achieve a goal.

Person-Centered, Goal-Oriented Care: A Self Determination Theory-based, person-centered conceptual framework that focuses health improvement efforts on the goals and priorities of the individuals seeking care.

Principles of Person-Centered, Goal-Oriented Care:

1. GOC is a conceptual framework or mindset, not a technique or tool. Since the four goal categories are known, goal-oriented care is more about goal clarification, prioritization, alignment, and strategic planning than goal-setting per se.
2. The process (connecting, co-creating, collaborating) is, at least, as important as the outcome (goal-achievement).
3. Use of the word *goal* with patients is rarely necessary or helpful. When the desired outcome is unclear, it is more helpful to ask what the patient hopes to see happen and why.
4. Problems are viewed as risk factors, obstacles, challenges, and/or opportunities rather than undesirable abnormalities.
5. Biological variation is considered to be both a given and, in general, a good thing, and the concept of *normal* is largely irrelevant since comparisons are to oneself over time.
6. Normalization as a concept is replaced by optimization.

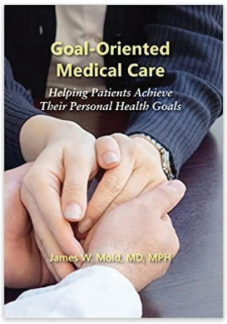
REQUIRED MINDSET SHIFTS

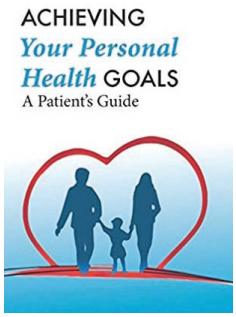
1. **From problem-solving to goal attainment**
   a. From *What's the matter with you?* to *What matters to you?*
   b. From deficit reduction (restoration of normality) to optimization.
   c. Reconceptualization of problems as obstacles, challenges, and opportunities, and reframing interventions as strategies.
2. **From standardization to individualization**
   a. From comparing people to each other to comparing individuals to themselves over time.
   b. From trying to achieve standard quality metrics to trying to align strategies with individual patient goals and priorities.
3. **From doing everything possible to prioritizing interventions based upon desired outcomes**
   a. Focusing time and energy on the most impactful strategies.
   b. Limiting the number of interventions based upon threshold principle and the law of diminishing returns.
4. **From transactional to interactional**
   a. From working independently on discipline-specific problems to working collaboratively toward common goals (multi-disciplinary to interdisciplinary)
5. **From the hierarchy of an expert - patient relationship to partners and collaborators**

COMMON CONCERNS AND MISCONCEPTIONS

1. **Primary care clinicians already do this.**
    a. Probably not in any sort of consistent or organized way. There is often a gap or misperception in what we think we do and what we do. **Quality improvement must be structured and measured** to be successfully implemented. A chart audit or survey usually demonstrates the gaps.
2. **It will take more (too much) time.**
    a. It takes no more time than good problem-oriented care if organized and integrated into your workflow. It may actually save time by prioritizing care more appropriately to what matters most to the patient. Pre-visit questionnaires (homework) can lead to effective and efficient visits.
    b. It probably does require a dedicated visit each year to address prevention and good death planning.
3. **What about the current quality indicators?**
    a. Unknown. Adherence probably improves but standard quality indicators are not applicable to all patients. Other measures will be addressed in the Monitoring section.
4. **How will patients respond?**
    a. Most like it a great deal when done well. It's the way most people think, and this approach addresses how they view health, and what they want from their health care providers.
5. **What if a person's goals are unrealistic?**
    a. It isn't always necessary to insist upon realistic goals in order to begin a plan of care. Adjustments to the care plan are an expected part of the process. However, the goals must be believable enough to motivate actions.
    b. Reframing techniques can be employed to avoid disappointment and discouragement
    c. Nurturing hope is a reasonable strategy as the clinician guides the person to acceptance.
6. **What if the clinician doesn't agree with the person's goals?**
    a. This is an unusual occurrence, but one which requires negotiation to find common ground or dissolution of the relationship if the patient's goals, objectives, or strategies are outside the practitioner's comfort zone or boundaries. Some clinicians may have a difficult time respecting and pursuing the person's goals while also trying to practice evidence-based medicine. A person's goals and desires may conflict with standard of care and health plan measures and clinicians need to establish their boundaries.
7. **How do subspecialists react?**
    a. Variable. This requires specialist referrals with specific, clear articulations of what the provider wants answered or scope of work to be done that is accompanied by an explanation of patient goals to help guide the specialist intervention. The specialist needs to be encouraged to be part of the same team working toward the same goals.
8. **Is there a danger of missing something important?**
    a. This approach does not eliminate or supplant the tenets and teachings of comprehensive primary care medicine. It does require well-designed processes and caution, especially at initial evaluations, to make sure you have all relevant information.
9. **What do primary care clinicians who have tried this approach think of it?**
    a. While the transition can take some time, once mastered, primary care physicians like this approach a great deal. It is the approach that many experienced physicians have developed themselves over time.
    b. To do it well requires an even greater knowledge of medicine and better interpersonal skills. The rewards include closer relationships with patients, more interesting clinical challenges, and better clinical outcomes.

BEFORE GETTING STARTED:





1. Purchase and read *Goal-Oriented Medical Care: Helping Patients Achieve their Personal Health Goals* by James W. Mold, MD, MPH as your textbook. You will need it for reference. Before making changes in the practice, it is most important to read the Preface (pages i-vi), Introduction (pages viii-xxii), and the introduction to Section 1, Principles of Goal-Oriented Care (pages 1-2). If you will be including patients or patient representatives on your implementation team, suggest that they purchase and read *Achieving Your Personal Health Goals: A Patient's Guide* also by Dr. Mold.
2. Review the Expert Recommendations for Implementing Change (ERIC) Study Concept Mapping[13] (Link) to inform important steps in transformation, such as:

    a) creating a project plan and logic model,

    b) identifying and preparing a Clinician Champion,

    c) building an implementation team, and

    d) involving patients and family members.

    Each of these steps will support creating and improving workflows, as well as, in designing tools, documents and resources.
3. Set your personal expectations as follows:

    - Anticipate transformation to initially take at least two years. This is a new workstyle of healthcare that will become habitual, but will continue to evolve for a lifetime.
    - Prepare to spend at least six months on each section of the implementation guide (a linear iterative process). Alternatively, some organizations may find that working in small steps on all sections at once is more realistic.

[13] Waltz et al. Implementation Science (2015) 10:109. DOI 10.1186/s13012-015-0295-0

RESOURCES:

Several published sources of this information include:

1. Goal-Oriented Medical Care: Helping Patients Achieve their Personal Health Goals by James W. Mold, MD, MPH
2. Goal-Oriented Care: A Shared Language and Co-Creative Practice for Health and Social Care by Pauline Boeckxstaens, MD, PhD, Dagje Boeykens, OT, Jean Macq, MD, PhD, and Phillipe Vandenbroeck, MA
3. Achieving Your Personal Health Goals: A Patient's Guide by James W. Mold, MD, MPH
4. https://en.wikipedia.org/wiki/Goal-Oriented_Health_Care
5. https://www.goalorientedcare.org
6. Mold JW. Goal-directed health care: Redefining health and health care in the era of value-based care. Cureus 2017; 9(2): e1043. http://www.cureus.com/articles/5935-goal-directed-health-care-redefining-health-and-health-care-in-the-era-of-value-based-care?utm_medium=email&utm_source=transaction
7. American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A Definition and Essential Elements. J Am Geriatr Soc. 2016 Jan;64(1):15-8.
8. Steele Gray C, Grudniewicz A, Armas A, Mold J, Im J, Boeckxstaens P. Goal-Oriented Care: A Catalyst for Person-Centred System Integration. International Journal of Integrated Care, 2020; 20(4): 8, 1–10
9. Mold JW. Failure of the problem-oriented medical paradigm and a person-centered alternative. Ann Fam Med 2022; 20:145-148.
10. Mold JW, DeWalt DA, Duffy FD. Goal-Oriented Prevention: How to Fit a Square Peg into a Round Hole. Journal of the American Board of Family Medicine, Mar 2023; 36: 333-338.
11. Mold JW and Duffy FD. How patient-centered medical homes can bring meaning to health care: A call for person-centered care. Annals of Family Medicine, 2022; 20(4): 353-357.

MODULE 2

PREPARING FOR THE CHANGE:

- STEP 1 — Clarify Your Practice Vision
- STEP 2 — Identify the Clinician Champion and Practice Champion
- STEP 3 — Create an Implementation Team
- STEP 4 — Prepare your team
- STEP 5 — Gain Acceptance

2

STEP 1 CLARIFY YOUR PRACTICE VISION

Before deciding to implement Goal-Oriented Care envision why you want to do it. Practices tend to have four major goals:

1. Generate income for clinicians and staff (financial survival and rewards)
2. Create a workplace that promotes joy and fulfillment for those who work there and has the resources you need to do your job (quality of work life)
3. Provide the best possible care to each patient (role fulfillment, purpose).
4. Improve community health and contribute to a greater good (meaning and purpose).

Of these, implementation of goal-oriented care seems most directly related to enjoyment of work and quality of care.

STRATEGIC QUESTIONS:

- What are your values?
- What motivates you?
- What is the patient experience you want to create?
- What does a great day in practice look like for you?
- What can be realistically achieved in your setting?
- Which goal noted above is most important for your practice at this time?
- How important is it?
- Is it compelling enough to justify the effort that will be required to make the significant behavior changes required?
- Does implementing goal-oriented care align with your vision and practice mission?
- What are you willing to compromise to achieve your goals?
- How will the workflow be impacted? Who will be impacted? Will you need additional staff?
- Will patients, staff and clinicians accept this change? What are their pain points? Will PC-GOC alleviate them?
- Is it the right time to implement a change? Do you have the time and resources to move forward at this time?

TASKS:

- Create your PC-GOC Change Committee (the social leaders of change initiatives) that consists of 3-4 people and includes a key clinician, practice management and other staff that are aligned with this change and represent other departments or sections of your organization. A patient representative would be a valued addition.
- Meet with your PC-GOC Change Committee to answer these questions, clarify your vision and write it down
    - Inventory your personal values and beliefs combined with your experience to conceptualize what needs to change. This is your vision.
    - Review CFIR domains and constructs to identify strengths and barriers [https://cfirguide.org/constructs/]. See list in Appendix 2
- Survey your practice to gather information on how your practice feels about this concept.
- Review the financial considerations. What will be the costs with implementing and sustaining this transformation?
- Host a Café Conversation (a facilitation method) to identify themes and questions that are foundational to exploring a concept before implementing changes. See Appendix 3.

2

RESOURCES:

1. Hammond R, A Real-Life Story on Getting Started: Designing a Foundation (2019) in Gold S, Green L. Integrated Behavioral Health in Primary Care Your Patients are Waiting (pp 3358). Springer. https://doi.org/10.1007/978-3-319-98587-9.
2. Kotter J, Leading Change. Boston. Harvard Business Review Press. 1996.
3. Consolidated Framework for Implementation Research https://cfirguide.org/
4. Waltz et al. Implementation Science (2015) 10:109 https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-015-0295-0.pdf

STEP 2 IDENTIFY THE CLINICIAN CHAMPION AND PRACTICE CHAMPION

1. Canvas the clinician and administrative leadership at the practice to ascertain interest.
2. Meet with potential candidates and discuss the program, expectations and requirements.
3. Determine the amount of carve-out time and renumeration, if appropriate, that the Clinician and Practice Champion will be given to implement this project.
4. Obtain a commitment

STRATEGIC QUESTIONS:

1. Why is implementation of GOC important for your practice?
    a. Examples:
    i. Higher quality care for individual patients
    ii. Greater enjoyment of practice
    iii. Greater patient satisfaction
    iv. It would set our practice apart and ahead
    v. It's the right way to take care of people
2. What gaps do you hope GOC could fill in your practice?
3. Is your practice ready for change?
    a. Is your practice financially stable?
    b. Do you have the leadership to be successful?
    c. Do you have a cohesive team?
    d. Are there competing priorities?
4. Do you have the capacity to make change at this time?
5. Do you have the time to devote to implementation?
6. Do you have the staff to support implementation?
7. What needs to happen to feel fully engaged and energized to move towards GOC

TASKS:

1. Clinical leaders need to read Goal-Oriented Medical Care: *Helping Patients Achieve their Personal Health Goals* by James Mold MD, MPH.
2. Patient leaders need to read *Achieving Your Personal Health Goals: A Patient's Guide* by James W. Mold, MD, MPH
3. Explore the information and videos provided on www.goalorientedcare.org and the resources listed below.
4. Interview and select your Clinician and Administrative Champions
5. Educate your champions on leadership and how GOC supports the practice vison and mission.

RESOURCES:

1. Healthcare Executive. The Dyad Leadership Model: Four Case Studies. Sept/Oct 2017: 32-40. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjYmrXAqeb-AhUKZcAKHXt6Do8QFnoECAsQAQ&url=https%3A%2F%2Fwww.asahq.org%2F-%2Fmedia%2Fsites%2Fasahq%2Ffiles%2Fpublic%2Feducation%2Fother%2Fdyad-leadership-model-healthcare-exec.
2. Kotter J, Leading Change. Boston. Harvard Business Review Press. 1996.
3. Leadership is a Learned Skill. Taylor. Family Practice Management. Oct 2003:43-48.
4. The Power of Two. Wagner. 2006. https://news.gallup.com/businessjournal/111826/power-two.aspx

STEP 3

CREATE AN IMPLEMENTATION TEAM

The Implementation Team is made up of a small group of people in your practice (usually 5-8) who share the vision, represent all departments or sections of the organization, and have the power to act. Their role is to empower broad-based action throughout the clinic departments to create a whole practice team effort. This is the nitty-gritty implementation of operations and workflows that require the input and buy-in of the whole group.

STRATEGIC QUESTIONS:

1. How can you determine if you have the right providers and staff for this change?
2. Who should be part of the Implementation Team? Have you represented the whole practice?
3. What will it take to implement this change?
4. How will the practice look different when you have implemented PC-GOC?

TASKS:

1. Determine the respected leaders in your practice in all departments
2. Decide who best adopts the vision and mission of the practice
3. Interview selected candidates and invite those who have the interest and willingness to implement PC-GOC
4. To benefit from Module 2, assemble an implementation team with the credibility and ability to drive change and includes:
    1) A Quality Improvement Lead (QI Lead)
    2) A Clinician Champion
    3) A Tracking and Monitoring Lead
    4) At least one representative from each functional area of the practice (clinicians, medical assistants, front office, back office, lab/X-ray).
    5) At least one patient representative or patient advocate.

Position	Time Commitment	Role Characteristics	Responsibilities
QI lead (required)	2-8 hours per month	☐ QI experience. Interest in topic	☐ Leads the day-to-day work ☐ Organizes meetings ☐ Oversees PDSA cycles
Clinical champion (required)	2-4 hours per month	☐ Interest in topic ☐ Influence in the organization	☐ Builds consensus among clinicians and staff ☐ Maintains leadership support ☐ Lead clinical voice
Tracking and Monitoring Lead	Variable depending on your system, 4+ hours per month	☐ Protected time for tracking and monitoring ☐ Technology skills ☐ Access to records/data	☐ Works with data to develop and generate reports
Other in practice	2-4 hours per month	☐ Participates in team meetings and PDSA cycles	☐ Represents roles important to team-based care
Patient or Patient Advocate	2 hours per month	☐ Participates in team meetings	☐ Represents the interests of patients

TASKS: CONT.

5. Set up regular weekly meetings to create the environment, infrastructure, workflow, tools and culture to implement GOC

a. Build trust in the team and set ground rules to make effective and actionable meetings

b. Agree on a common goal that makes sense to delivering optimal medical care and appeals to the emotional aspects of healing relationship

6. Create a timeline and milestones for implementation

7. Determine the activities and measures that will reflect how success will look.

a. Ann Fam Med 2019;17:221-230. https://doi.org/10.1370/afm.2393.

RESOURCES:

1. Kotter J, Leading Change. Boston. Harvard Business Review Press. 1996.

2. Barba C, A Real-Life Story Getting Started: Building from the Ground Up (2019) in Gold S, Green L. Integrated Behavioral Health in Primary Care Your Patients are Waiting (pp 59-102). Springer. https://doi.org/10.1007/978-3-319-98587-9.

STEP 4

PREPARE YOUR TEAM

Create a collaborative vision that is clear, practical, and achievable that works for your practice from the perspectives and guidance of your PC-GOC Implementation Team. To engage providers and staff, you must communicate that vision repetitively, and adjust it to different points of view to capture the different beliefs of providers and staff. Each individual has their own purpose for being in your practice and it is important to make it clear to them how this change will match their goals and priorities.

STRATEGIC QUESTIONS:

1. What drives change or quality improvement in your practice?
2. What barriers may you face?
3. How will implementing this change affect the culture of the practice and the emotional health of the providers and staff?
4. How will this change affect the workflow?

TASKS:

1. If possible, meet with each staff member to assess what meaning they derive from working at the practice, what drives them, and evaluate their readiness for change, as well as, what barriers and fears they may have in making change. Their insights will inform your process and policies.

GAIN ACCEPTANCE

Once the implementation Committee has reviewed the pros and cons of implementing PC-GOC, and before actually creating an implementation plan, it is important that the initiative has the support of the entire practice and/or organization. While levels of knowledge and interest will differ, everyone needs to at least be willing to support the effort.

1. Either convene a staff meeting and/or prepare and distribute a one-page summary of PC-GOC to practice clinicians and staff and a general implementation proposal that includes:
    a. The name of the initiative
    b. The reasons to do it
    c. The anticipated timeline
    d. The key individuals involved and their roles
    e. The estimated time requirements and responsibilities for those who are not on the Implementation Committee
    f. The availability of external resources (funding, facilitators, and outside experts)
    g. A few references for those who want more information
2. Create a Logic Model
3. Assign someone from the Implementation Committee to meet individually with all staff, if possible, or in larger groups with anyone who has questions or concerns and with anyone who could be a particularly important advocate or resistant.
4. Hold an all-practice/organization meeting to discuss the initiative.
5. Devote some meetings of the practice's Patient Advisory Committee (PAC) to a discussion the initiative. If the practice doesn't have a PAC, consider assembling a representative group of patients to advise the practice/organization on this specific project only. At least one member of this group should agree to represent the group on the Implementation Committee.
6. With substantial input from patients, prepare a description of PC-GOC for patients that can be made available in the waiting room and exam rooms once implementation begins. Here is an example.

GOAL-ORIENTED HEALTH CARE

Much of the medical care you have received in the past has focused on solving problems. The assumption is that correcting abnormalities will result in a longer and more enjoyable life. However, that is an indirect approach that can be somewhat mechanical and impersonal and can too often result in unnecessary tests and treatments.

We are trying to develop a more direct and positive approach. We hope to help you develop a plan of care based upon your personal values and your health-related goals and priorities. Focusing directly on your goals and priorities helps assure that tests and treatments will be relevant.

We assume that you want to live as long as possible up to the point when life is no longer worth living, and that you want to be able to do the things that you enjoy and find meaningful. We hope you also want to become stronger and more adaptable and resilient, and at the end of your life, we would like for you to have a good death. While we all have those goals in common, each of us has a unique set of risk factors, resources and strengths, values, hopes, preferences and priorities.

Our intention is to create a long-term relationship with you and, if possible, with your family in whom we can work together to help you achieve your goals in the ways that you define them. That will require a somewhat greater investment on both of our parts than what you may have experienced with your previous health care providers.

As soon as possible we would like to schedule a new patient evaluation and wellness visit. Prior to that visit, we are assigning some homework. Please complete the attached questionnaire to the best of your ability. Also, complete and sign the Request for Medical Records forms for each medical practice in which you have been seen more than twice or had laboratory or other tests (X-rays, colonoscopies, etc.) done within the last 5 years, and each hospital in which you were either seen in the Emergency Department or admitted overnight during that same time period. Bring the completed questionnaire and signed forms to your visit along with all of the medications and supplements you take on a regular basis in a plastic bag or other suitable container.

Step 5.6: Assign someone to lead an effort to change the culture of the practice.

a. Consider posters and or signage throughout the practice with messages like:

   Moving from:

   What's the matter with you? → What matters to you?

   Normal → Optimal

   We strive to help each person have a long, fulfilling life

   Universal Goals: Prevent premature death, maximize quality of life, optimize personal growth and development, and experience a good death

   Don't forget to schedule your annual For-As-Long-As-Possible Preventive Care visit

b. Consider penalties for using problem-oriented terms.

   At the end of the initiative, a raffle or quiz could be held to award the funds.

Problem-Oriented Words	Goal-Oriented Words
Problem, disease, condition	Obstacle, challenge, opportunity, risk factor
Normal	Optimal
Treatment	Strategy
Target, clinical/medical goal	Objective
Compliance/adherence	Miscalculation
Manage, control	Co-create, collaborate

c. Use an all-practice meeting to discuss the mission and goals of the practice and send practice-wide emails or newsletters on success stories. Get stories from staff on how it changed their job and positively affected care. Most practices have the following goals: 1) provide the best possible care to each person; 2) create an environment in which clinicians and staff can flourish; 3) maintain financial viability; and 4) contribute to improving the health of the community.

RESOURCES:

1. Bodenheimer T, Laing B. The Teamlet Model of Primary Care. Ann Fam Med. 2007;5:457-461.
2. DeMent J. Managers, leaders, and teams in a team-based environment. Hosp Mater Manage Q. 1996 Aug; 18(1): 1-9.
3. Joosten Tom et al. Application of lean thinking to health care: issues and observations. Int J Qual Health Care. 2009 Oct; 21(5): 341-347.

MODULE 3

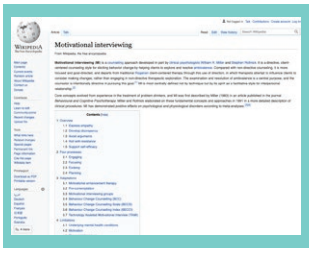
UNDERSTAND THE CHANGE:

- STEP 1 — Learn Narrative Medicine and/or Motivational Interviewing Methods
- STEP 2 — Understand the Concepts Underlying Goal-Oriented Care
- STEP 3 — Learn about Each of the Four Goal Types

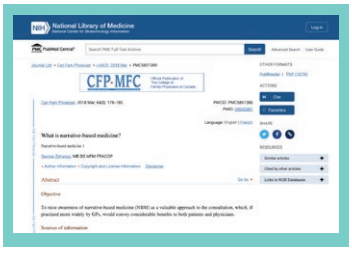
STEP 1

LEARN NARRATIVE MEDICINE AND/OR MOTIVATIONAL INTERVIEWING METHODS

RESOURCES:



Motivational Interviewing - https://en.wikipedia.org/wiki/Motivational_interviewing



Narrative Medicine - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851389/

STEP 2

UNDERSTAND THE CONCEPTS UNDERLYING GOAL-ORIENTED CARE

RECOMMENDED FIRST STEPS:

It makes sense to take foundational steps first, since it will make subsequent steps easier. Here are some recommended first steps.

Conceptualizing Goal-Oriented Care

Some time when you are not working, answer the following questions about yourself. Feel free to discuss the questions and your answers with your family or close friends.

a. What do you hope to experience before you die (your bucket list)?

What is one thing you could begin doing today that might increase your length of life and so that you can experience those things?

b. What are the activities and relationships that you value most?

c. What is a next important step in your personal growth as a human being?

d. What conditions would, for you, be worse than death?

e. What would a good death look like for you?

How might the answers to these questions be important to your physician or your family in helping you make healthcare decisions that are right for you?

Key Concepts:

1. "It's far more important to know what person has the disease than what disease the person has" – Hippocrates. In an 1899 address to students in the Albany Medical College, Sir William Osler advised, "Care more particularly for the individual patient than for the special features of the disease." Francis Peabody, in a 1927 *Journal of the American Medical Association* article, wrote, "The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal."
2. Until life extension is no longer a goal, all patients have goals of all four types. Don't just focus on Quality Of Life and ignore the others. Trade-offs are almost always important.
3. Instead of organizing care around a problem list, connect the patient's symptoms or concerns to their personal goals, values, beliefs and preferences and you will engage them as an active participant in their care. Focus on the person, not the problem.
4. Take shared care to a new level – collaborative care – where the patient and provider work together on common goals. The patient contributes information about needs, desires, resources, values and preferences and the provider contributes information on medical options, obstacles and probabilities.
5. When diseases, abnormalities, and vulnerabilities increase the probability of future adverse outcomes, they are reconceptualized as risk factors. For example, elevated blood pressure is not viewed as a disease, but rather as a factor that can increase the risk of future adverse cardiovascular events and an earlier death.
6. Instead of simply diagnosing and solving problems, focus on helping patients clarify and then achieve their goals..

GOC allows the provider to practice for the reasons that they were attracted to primary care and in the way they were trained. This decreases the stress and demands of achieving the goals of the health care system instead of the patient's goals and allows the provider to return to the joy of practicing medicine.

General Tasks When Getting Started

1. Reading Assignments or lectures delivered at weekly/monthly/quarterly meetings

    a. Clinicians and clinical staff

    Goal-Oriented Medical Care: Helping Patients Achieve their Personal Health Goals

    b. Non-clinical staff and patients

    Achieving your Personal Health Goals: A Patient's Guide

2. During each patient encounter, think about one of the four goal types, the one most applicable to the reason for the visit.

    a. For the prevention goals, think about life expectancy and the most likely causes of death and disabilities.

    b. For quality-of-life goals, think about how the patient's health challenges might be affecting their daily activities and relationships.

    c. For growth and development goals, consider what developmental challenges or life transitions the patient might be facing and how they might continue to build physical and psychological resilience, and

    d. For the good death goal, notice whether you have documented end-of-life preferences.

3. Don't share these thoughts with the patients unless you want to. Just practice and get in the habit of matching goals with patient encounters. Write them down on a piece of paper for later reflection and discussion.

STEP 3

LEARN MORE ABOUT EACH OF THE FOUR GOAL TYPES

1. Preventing Premature Death and Disability

a. Read Chapter 1a and 1b - Prevention of Premature Death and Disability (Text – pages 3-34) if you are a clinician or Chapter 1 (pages 6-26) in *Achieving Your Personal Health Goals* if you are not. Consider engaging in a group discussion of the questions at the end of the chapter in *Achieving Your Personal Health Goals*.

b. Over the course of several days or weeks, choose an appropriate patient every day who has a chronic medical condition, and try viewing their condition as a risk factor, similar to an unsafe neighborhood, a sedentary lifestyle, or an unhealthy diet, for future premature death or disability, rather than simply an abnormality that needs to be corrected.

c. Consider how you might incorporate periodic evaluations (e.g., annual comprehensive assessment of risks, vulnerabilities, and resources) into your workflow to create a profile of risk factors, resources, preferences, and most likely cause of death or disability in order to develop a care plan of objectives and strategies that will have the greatest impact on extending life expectancy and reducing disability?

d. Learn how to identify and prioritize risks and available risk reduction strategies to prevent premature death and decrease future disability.

   i. Focus on the patient's most likely causes of premature death or disability (see Appendix D of the *Goal-Oriented Medical Care*)

   ii. Place these risks into medical, behavioral, social and environmental categories.

   iii. If potential causes are undetermined, focus first on biological needs and social determinants of health.

e. The patient's strengths, resources, preferences and trade-offs need to be explored in order to match medical options to the patient's goals in a collaborative fashion. This information is best obtained from questionnaires that are completed prior to the visit. What information do you need and how will you get it? The Patient Profile developed at Westminster Medical Clinic is an example.

f. Create or obtain decision support tools to help you and your patients prioritize preventive strategies. You will, for example, want to have charts of recommended primary and secondary preventive services, as well as, information on life expectancies by age, gender, race, and certain medical conditions (see Appendix D in GOC textbook)

   Consider contacting either Zsolt Nagykaldi at the University of Oklahoma (Zsolt-nagykaldi@ouhsc.edu) or Glenn Taksler at New York University (TAKSLEG@ccf.org) to see if they would let you use their health risk appraisal tools in order to further improve them or as part of an effectiveness study.

g. Identify practice or community evidence-based support systems for common, significant preventive challenges (e.g., smoking, alcoholism, drug addiction, other addictions, physical inactivity, unhealthy eating, disordered sleep) to be available to your patients.

h. A clinical care pathway is the care plan that will outline the intervention strategies. Try creating a clinical care pathway for a real or imagined patient (See Appendix E of *Goal-Oriented Medical Care*)

2. Maximizing Health-Related Quality of Life (HR-QOL)

a. Read Chapter 2a and 2b (pages 35-57) if you are a clinician or Chapter 2 (pages 27-53) in *Achieving Your Personal Health Goals* if you are not. Consider engaging in a group discussion of the questions at the end of the chapter in *Achieving Your Personal Health Goals*

   i. Similar to the prior section, over several days or weeks, choose an appropriate patient every day whose major concern seems to be current quality of life, and try to identify activities and relationships important to them. Ask "Walk me through a typical day in your life" and "What activities/relationships are giving you trouble?" Ask yourself, what did you learn that you did not know? Will it change your care plan?

b. Next determine desired activities and relationships

   i. What would you like to be able to do that you can't do now?

   ii. What activities and relationships are most important to you?

c. Clarify values underlying those activities and relationships

   i. Why are those activities and relationships important?

d. Identify obstacles, challenges, opportunities, and trade-offs

   i. What is preventing you from doing those things? How else might you be able to satisfy those needs?

e. Practice the concepts and reflect on how it changes the patient, you, and the visit. What works? What doesn't? Go back to your resources to refresh your understanding and reflect on what to try next.

f. Create your medical neighborhood

   i. Get to know an occupational therapist and a physical therapist in your area (see Westminster Medical Clinic Medical Neighbor Compact.

      1. Schedule a lunch meeting.

      2. Visit their practices.

      3. Discuss scopes and philosophies of practice.

      4. Discuss charges and insurance coverage for their services.

      5. Discuss best ways to manage referrals and consultations.

   ii. Get to know a mental health professional who is skilled in cognitive behavioral therapy and is willing to help patients make difficult behavior changes.

g. Write down a sample plan or your reflections of the above activities.

h. Construct a clinical care pathway to support the plan

i. Health coaches are extremely valuable in implementing strategies and supporting and achieving the plan. https://link.springer.com/article/10.1007/s11606-010-1508-5

j. Reevaluate and adjust the plan based upon experience and results

3. Optimizing Personal Growth and Development

a. Read Chapter 3 (pages 58-63) of *Goal-Oriented Medical Care* if you are a clinician or Chapter 3 (pages 55-66) in *Achieving Your Personal Health Goals* if you are not. Consider engaging in a group discussion of the questions at the end of the chapter in *Achieving Your Personal Health Goals*

b. Identify courses and other educational resources on resiliency.

   i. Learn about and have available the Erikson's developmental stages. Link

   ii. Learn about Deci and Ryan's Theory of Self Determination (connectedness, autonomy, competence). Link

   iii. Learn about psychological resilience as a concept and its components. Link

c. Over several days or weeks, choose a patient every day, and, based upon their age, consider their developmental stage. Consider ways you could incorporate that understanding into your conversation with them and how you might promote and encourage development of greater psychological resilience. Write down a sample plan or your reflections of the above activities.

   i. Begin to think about the relevance of those conceptual frameworks to particular people.

   ii. Try to incorporate at least one principle from one of those models.

   iii. In every encounter, begin to think about how that event fits into the patient's life trajectory. What were the antecedents? Has it happened before? Will it probably happen again? What can the patient do to prevent and/or deal with its reoccurrence?

   iv. Try to make sure that every encounter is an educational event and that the patient leaves better prepared to face similar challenges in the future.

d. Get to know a mental health professional in your area who can help patients with developmental challenges (attachment disorders, occupational challenges, marital challenges, dealing with losses and aging, etc.).

4. Increasing the Probability of a Good Death

a. Read Chapter 4: A Good Death (pages 64-75) of *Goal-Oriented Medical Care* if you are a clinician or Chapter 4 (pages 67-79) in *Achieving Your Personal Health Goals* if you are not.. Consider engaging in a group discussion of the questions at the end of the chapter in *Achieving Your Personal Health Goals*.

b. Assemble materials and resources needed to assist patients with end-of-life planning including information about various advance directive documents, the documents themselves, other educational materials (e.g., information to share with family members about locations of important documents, etc.), and links to online resources.

c. Establish a process for routinely and periodically addressing end-of-life directives. We suggest including this in the annual prevention homework and visits. Determine how to ask every adult patient routinely and periodically what conditions they consider to be worse than death. One way to facilitate that discussion is to give patients a list of potential options as part of their homework assignment. (e.g., living alone, unable to live independently, unable to make decisions , living in a nursing home, unable to recognize family members, unconscious with no hope of ever waking up). Upon reviewing their choices ask, "So, if you found yourself in that condition, and it wasn't going to improve, and you then developed pneumonia, you wouldn't want me to give you antibiotics?"

    1. Document their final list of intolerable conditions

    2. Find out from every adult patient who they trust to:

        a. Receive medical information.

        b. Participate in medical decisions.

c. Serve as their health care proxy if they are unable to make medical decisions.

d. Discuss end-of-life values and preferences

e. Encourage every adult patient to complete an advance directive and durable power of attorney and provide you with a copy.

MODULE 4

MAKE THE CHANGE

STEP 1	**Behavior Change Requirements**
STEP 2	**Generate Short Term Wins by Taking Small Steps**
STEP 3	**Consolidate the Gains**
STEP 4	**Meet Regularly**
STEP 5	**Develop a New Habit**
STEP 6	**Begin implementation**
STEP 7	**Get Support**

You should now have your team in place, a good understanding of PC-GOC and the resources you need for full implementation. It is recommended to work in several areas at a time, in parallel, according to your timeline. If instead, you plan to implement one goal at a time, be aware that there may be some overlap between the prevention of premature death/disability and good death goals since both involve preventive strategies and so could be handled during annual visits.

STEP 1

BEHAVIOR CHANGE REQUIREMENTS

Long term behavior changes require all of the following components. You have already made the decision to implement PC-GOC. It will be important to regularly remind members of the practice why you decided to do it and the implementation plan (e.g., with practice signage, printed material, and presentations). Individuals resisting the process should be consulted and brought on board if possible.

1. A decision to change the behavior for the life of the practice.
2. A compelling reason to do it (e.g., to improve patient care and/or satisfaction with care or to enhance the joy and fulfillment of those work in the practice).
3. A plan that is both feasible and acceptable over the long term.
4. Individuals who provide ongoing encouragement and support (e.g., practice champions or patient advocates). It is also important that there not be influential individuals that are opposed to and work against the change.
5. A plan for maintaining momentum during times of unexpected challenges and for dealing with lapses and setbacks.

Note: Those same components are required for individual behavior change.

4

STEP 2

GENERATE SHORT TERM WINS BY TAKING SMALL STEPS

To achieve your ultimate goal of GOC implementation, you will need to progress through a series of operational reorganizations and performance improvements. To keep the providers and staff aligned, empowered, and inspired to stay the course, celebrating short-term wins help to both justify and reward the work and effort and breach barriers along the way.

STRATEGIC QUESTIONS:

1. What does success look like?

TASKS:

1. Survey members of the practice regarding what success would look like to them.
2. Plan for clear and visible short-term wins
3. Decide on the milestones you would want to reach according to your timeline. Which of these milestones would serve as a short-term win?

   A short-term win should be visible, non-ambiguous and clearly related to the change.

RESOURCES:

1. https://thenicl.com/the-importance-of-short-term-wins/
2. https://www3.pinkelephant.com/ressource/pinklink/na/issue145/Implementing-Quick-Wins-August-2013.pdf

4

STEP 3

CONSOLIDATE THE GAINS

Build off your small wins and move toward a complete transformation that is sustainable.

STRATEGIC QUESTIONS:

1. Are we still on the right course to achieve our goals?
2. What needs to change for us to stay on course?
3. How can we ensure that positive changes continue?

RESOURCES:

1. http://blog.synergetics.com/modernization/stage-7-consolidating-gains
2. https://managementisajourney.com/leading-change-step-7-consolidate-gains-and-implement-more-change/

TASKS:

1. Anchor the new approaches into your culture
    a. This requires developing a sense for a new set of shared values with lots of talk and reflection and some degree of compromise and tolerance. Anticipate possible turnover of staff or clinicians.
    b. Hire new employees who are aligned with this goal.
2. Frequently remind providers and staff of the short-term wins and what went right and what needs improvement.
3. Set new goals, if needed, keep the change process fresh and to maintain momentum toward GOC transformation
4. Periodically review your strategy to ensure it supports the intent of GOC implementation

4

STEP 4 MEET REGULARLY

Schedule regular (weekly or every other week) meetings of the implementation team and monthly meetings of the entire practice to review progress and agree on next steps.

STRATEGIC QUESTIONS:

1. How can these meetings turn into actionable results?
2. How can these meetings change the culture of the practice?
3. What will it take to get all attendees to participate?

TASKS:

1. Carve out the time
2. Create an agenda with clear intent for the meeting and actionable items to discuss
3. Be sure everyone has the agenda prior to the meeting
4. Establish ground rules to ensure trust and respect
5. Plan to include fun or wellness activities
6. Ensure that everyone speaks
7. Recap the discussion and the actions to be taken and who is responsible

RESOURCES:

1. How to build a team
    a. https://www.annfammed.org/content/annalsfm/12/2/166.full.pdf
    b. https://www.aafp.org/fpm/2012/1100/fpm20121100p19.pdf
2. How to run a meeting
    a. https://www.timedoctor.com/blog/effective-meeting/

4

STEP 5 DEVELOP A NEW HABIT

1. Gather and create your tools and resources

    a. Documentation

        1. Create an EHR visit template that includes preventive care plan support and follow-up. (see Appendix A in the book)

            a. Decide how you will identify and document risk factors derived from the patient questionnaire and your records.

                i. It might be possible to use the Problem List for this purpose, or you can choose to develop a template for annual visits that includes a section for risk factors. You will need to decide whether to make a list of risk factors for premature death and a separate one for disability or whether a single list will work for you. Remember that the most common causes of disability are musculoskeletal (arthritis, back pain, etc.), neurological (dementia, addiction, sensory losses) and cardiac (heart failure). Most of those causes are preventable to some degree.

            b. Develop a consistent way to document preventive care discussions, shared decision-making, and shared care plans.

            c. In order to avoid missing a new life-threatening medical challenge (remember, prevention includes treatment of existing challenges) include a complete review of systems and physical exam in the annual prevention visit. Alternatives may be to depend upon patients to report new symptoms when they occur or to check on patients periodically through the year to see if new symptoms have developed and do the examination in pieces during quality-of-life visits. For billing purposes, it may be necessary to separate the Annual Wellness Visit and the comprehensive H&P for older people.

        2. Create a Life and Health Timeline to be filled out by the patient prior to the visit.

        3. Create a Care Pathway template (see Appendix E in the book)

        4. Modify your referral documents to include the patient's goals and a specific question to be answered or request.

        5. Create a GOC Visit Checklist to provide a standardized and consistent process to review the chart and evaluate a patient.

    b. Clinical Decision Tools

        1. Choose your Life Expectancy tables and make them available

        2. Choose your Screening Test Benefit tables and make them available

        3. Choose your Quality-of-Life questionnaire and make it available

    c. Patient Education material

        1. Develop a script for you and your staff to use when explaining the purpose of routine prevention visits and goal-oriented care.

        2. Create a flyer and introductory letter explaining the GOC philosophy (see Appendix C in book).

        3. Adopt or modify the Patient Risk Questionnaire (see Appendix A in book)

        4. Create patient educational materials to support Care Pathways, as needed.

2. Establish Scheduling and Workflow

    a. Develop workflow diagrams for annual visits and routine visits that specify all the necessary steps, indicating who is responsible for each step and how they are to be carried out.

3. Pilot the Program.

An example:

    a. Select a specific population to test your workflow, for example:

        (1) 10 patients over 65 years old

        (2) During routine visit, the provider invites the patient to either return for an AWV or GOC visit after explaining the program.

        (3) Patient given the Questionnaire, Life and Health Timeline and Advanced Directives and any other forms at check-out and told to return at least 2 days prior to next visit.

        (4) The Medical Assistant checks to see if questionnaire has been returned by due date. If not, patient is contacted and appointment is rescheduled..

        (5) MA scans document into chart.

    b. Spread the Program when ready

        i. Establish routine comprehensive annual prevention visits with pre-visit homework for patients. (See Appendices A and B in the book.)

        ii. Develop a method for assuring the patients receive and complete homework assignment(s) prior to prevention visits and what to do when they don't or can't complete it prior to the visit. Consider how that information could be most easily entered into the medical record.

        iii. Think through the logistics of encouraging or "requiring" an annual preventive care visit for every patient in your practice over a certain age. Estimate how many of those visits there would be per day. You may start with specific populations and over time increase the number of your patients reached.

        iv. Think about how you would structure them (e.g., WCC visits to what age? For Medicare patients AWV only or combined with CPE or AWV and CPE separately).

        v. Calculate the estimated time requirements and reimbursement estimates. Think about how to mitigate lost revenues from no shows and cancellations.

        vi. Think about how you could help patients who are unable or unwilling to have an annual comprehensive visit with their prevention goals.

4. Establish your coding and billing practices

BEGIN IMPLEMENTATION

1. Promote patient awareness of this program through letters, flyers and email blasts
2. When you have your infrastructure in place and you feel your practice understands how to apply GOC, have each provider choose a test patient each week with whom they have a long-term relationship. Discuss the concept of goal-oriented care with them and provide them with feedback. This could be done at care management meetings.
3. During the visit
    a. Focus on the most relevant goal category.
    b. Initiate a dialog applicable to that type of goal.
    c. Brainstorm potential ways to achieve one of the patient's goals.
    d. Decide upon an initial plan that is feasible and potentially effective.
    e. Create your Care Pathway for each goal that includes the objectives, strategies, team and community resources. The acronym, GOALS, may help:
        1. **G**oals – summarize your patient's goals in each of the 4 categories, if applicable.
        2. **O**bjectives/Obstacles – what are the patient's objective that will help stay on the path to reach their goals? What are the obstacles that will need to be addressed?
        3. **A**ctions – What are the strategies that will help the patient meet their objectives?
        4. **L**inks – Who needs to be on your team including community resources to guide and support the care?
        5. **S**ustainability – What support or follow-up will the patient need to maintain their success?

Questions to help identify goals, obstacles and challenges during visits

1. When relevant begin asking patients one or more of the following questions:
    1. What is a typical day like for you? or "Tell me about a typical day in your life from the time you get up in the morning."
    b. What are the biggest challenges you face on a typical day?
    c. What does a really good day look like for you? What makes a day good?
    d. What would you like to do that you can't do now? What keeps you from, being able to do those things?
    e. How has life changed for you since the onset of your symptoms? What did you do before that you can't do now?
    f. What are the activities and relationships that mean the most to you?
    g. What are you hoping for?
    h. What things worry you?
2. Once you feel comfortable asking those questions, try asking "why" questions.
    a. Why are those activities and relationships so important to you

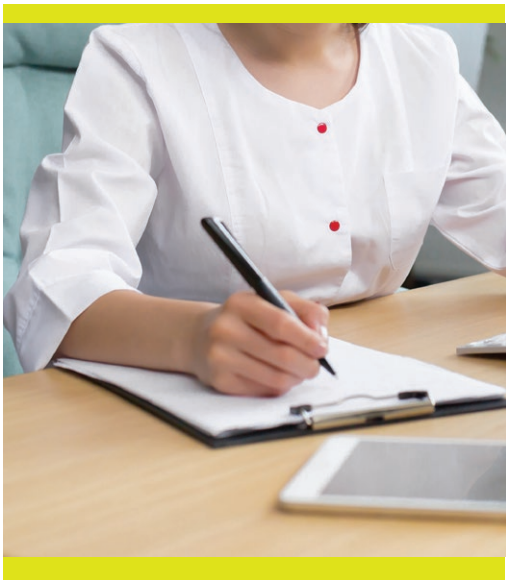
b. Why do those things worry you so much?

3. Rather than giving advice, try asking patients for suggestions regarding how to get to where they say they want to go. For example, as
    a. What are your thoughts about how you could [face that particular challenge]?
    b. What steps have you considered taking that might move you in that direction

c. What are you hoping I could do to help you get back to doing those things?

d. Are there things I have recommended that make it harder for you to get to where you want to be?

4. Keeping the focus on patients' stated "goals" and priorities, try to help them develop plans that have a chance to succeed. Those plans will generally include both medical and non-medical strategies.



STEP 7 GET SUPPORT

If there are gaps in your expertise in quality improvement or operations, seek advice from outside consultants for the support you believe you will need to accomplish your goals.

STRATEGIC QUESTIONS:

1. What keeps the team from adopting these changes?
2. What tools, services or support do you need to be successful?

TASKS:

1. Make a list of concerns and ask your consultants to respond to them.

4

MODULE 5

MONITOR AND SUSTAIN THE CHANGE:

Measures and Practice Performance Audits

Decide how you will measure the success of your implementation efforts.

Note: We also recommend manually reviewing the records of the last 10 qualifying patients seen during each PDSA cycle.

Prevention of premature death and disability

1. Patient care measures

- Percentage of patients with an annual preventive care visit
- Percentage of smokers advised to quit; proportion with plan
- Percentage of patients asked about physical activity. Percentage with plan to increase physical activity if relevant
- Percentage screened for sleep concerns, and percentage with plan to address them
- Percentage of patients with a nutritional assessment and percentage with plan to improve diet
- Percentage of patients > 45 with cardiovascular risk assessment
- Percentage of patients UTD on immunizations, pap, mammography, colonoscopy

2. Clinician-Self-Assessed Performance Measures

- Prevention of premature death is a high priority in this practice.
- We routinely assess a broad range of risk factors, strengths, and resources.
- We help our patients prioritize preventive strategies based upon their risk profiles.
- We typically advise against treatment of conditions that are likely to be self-limited.

Quality of life improvement

1. Patient care measures

- Daily activity challenges documented
- Desired activities documented
- Evidence that necessary and desired activities were considered when developing plan of care

2. Clinician-Self-Assessed Performance Measures

- We routinely suggest measures to reduce future sensory losses (hearing, vision, smell, taste, fine touch, position sense).
- We routinely suggest measures to enhance and preserve cognitive functions.
- We routinely suggest measures to reduce the future development and progression of musculoskeletal problems.

- Visit notes include information about valued life activities and relationships.
- Recommended interventions are clearly linked to specific valued life activities.
- Agreed upon lifestyle changes are clearly linked to specific valued life activities.
- Impacts on valued activities are used to assess the impact of symptom-reduction.
- We routinely remind our patients to allow their bodies to respond to illnesses and injuries when that is likely to enhance resistance to future insults.

Growth and development enhancement

1. Patient care measures
    - Evidence that relevant stage of life and/or developmental milestones were considered.
    - Evidence of discussion of life's meaning and purpose or aspirations for personal growth and development.
    - Evidence of discussion or consideration of building physical or psychological resilience.
2. Clinician-Self-Assessed Performance Measures
    - We routinely assess the developmental stage of children and adult patients.

- We help our patients prioritize strategies to achieve developmental milestones.
- We help our patients become more knowledgeable, adaptable and resilient to meet future health challenges.
- We have patient resources for resiliency training programs, mindfulness, meditation, yoga, Tai Chi.
- We prepare our patients to manage future episodes of conditions that tend to reoccur.

Improved death and dying process

1. Patient care measures
    - Percentage of Advance Directives discussions documented in chart.
    - Percentage of Advance Directive documents present in chart.
    - Documentation of conditions considered worse than death.
2. Clinician-Self-Assessed Performance Measures
    - We routinely discuss end-of-life values and preferences with all adults.
    - We advise and assist our adult patients to complete legal advance directive documents.
    - We advise our adult patients to discuss their end-of-life values and preferences with significant others.

Using the same measures for both patients and providers can reveal similar and different perceptions of the patient-provider relationship, and characteristics of that relationship where it might be helpful to focus your attention.

2. Patient satisfaction surveys
    a. Ann Fam Med 2019;17:221-230. https://doi.org/10.1370/afm.2393.
3. Provider and staff surveys
    a. Clinician/staff enjoyment/enrichment measures
        1. Enjoyment/enrichment survey
        2. Satisfaction, stress, burnout survey

To sustain the implementation of PC-GOC, clinicians and staff must belief what they are doing is meaningful and important. Certain activities fuel the culture building of PC-GOC within your practice.

Activities

- Story writing
    - Have the whole practice respond to this question - Why is Goal-Oriented Medical Care important to you and the practice? –collate the responses and share with the group.
        - Storytelling
    - At staff and care team meeting, share success stories of PC-GOC.
- Care team meetings
    - Present PC-GOC cases to discuss
- Personal feedback from Clinician and Practice Champions and patients
- Provide incentives when reach milestones
- Have regular celebrations when achieve a small win.

APPENDIX 1: IMPLEMENTATION FACTORS

The following is a proposed agenda for your change committee and implementation committee meetings. It is a list of factors that your team should consider before deciding to move forward with the implementation of PC-GOC. The items were derived from The Consolidated Framework for Implementation Research (CFIR).

Note: If you think you might someday want to produce a report or to try to publish the result of your implementation efforts, it could be helpful to document the answers to these questions.

Characteristics of PC/GOC that could affect implementation

1. **Source:** From what sources did you obtain information about PC-GOC. How much do you respect and trust those sources?
2. **Supporting evidence:** Are you satisfied that there is sufficient evidence to support making the changes required to implement PC-GOC? – What question(s), if answered, could make the greatest difference in understanding and implementing GOC? How would this change care in Family Medicine?
3. **Relative advantages:** What are the benefits of implementing PC-GOC that justify the effort required and the potential disruptions and other harms that it might cause? What opportunities do you see at your practice for GOC?
4. **Adaptability**: How can we adapt our practice to fit the PC-GOC model?
5. **Trialability:** Can we try out PC-GOC in a subset of clinicians and patients and in a way that will allow us to stop at any point and reconsider full implementation? Can it be implemented in stages?
6. **Complexity:** How difficult will it be for our clinicians and staff to make the transition to PC-GOC? When thinking about GOC, what assumptions exist and what needs to be challenged?
7. **Design quality:** How well have the approach and implementation methods been constructed, explained, and supported?
8. **Cost:** How much is it likely to cost us to implement PC-GOC?

The potential impact of external factors on implementation success

1. **Patient needs and resources:** What will be required to help patients make the adjustment to PC-GOC?
2. **Network impacts:** Will implementing PC-GOC have any impact on our current or future networks including consultants?

3. **Competitive pressures:** Will implementing PC-GOC have any positive or negative impacts on our ability to attract new patients? What about insurance contracts?
4. **External policies and incentives:** How will PC-GOC impact current quality and utilization metrics, incentives, and penalties?

The potential impact of internal factors on implementation success

1. **Practice structural characteristics:** What physical space is necessary to expand our teams (e.g., to add a mental health clinician, social worker, and/or physical or occupational therapist?)
2. **Communication and decision-making within the practice:** What channels of communication and decision-making processes do we need to make this change?
3. **Practice culture:** How well does PC-GOC fit with the norms, values, and assumptions of our organization?
4. **Implementation climate**
    a. Tension/impetus for change: What is driving us to implement PC-GOC?
    b. Compatibility/Fit: How well does PC-GOC fit us?
    c. Relative priority: How high is implementation of PC-GOC on our list of priorities?
    d. Organizational incentives and rewards: How and in what ways will we each benefit?
    e. Alignment of goals and feedback: How will we know if it was the right thing to do?
    f. Learning climate: Does our organization value continual professional development?
5. **Readiness for implementation**
    a. Leadership engagement: Are the major decision-makers on board and enthusiastic?
    b. Availability resources: Do we have everything we need to do this?
    c. Access to knowledge/information: Will we be able to access additional information?

APPENDIX 2

A. Plan–Do–Study–Act (PDSA) Cycles

The easiest and safest way to implement new processes is to conduct a series of small, short-term experiments.

1. As an implementation team, **plan** a step forward, then do it with a small number of patients over a one-two week period, then study how well it worked, then act on the information you gained.
2. **Planning** includes setting a start date and a defined end of trial, and assigning someone to make sure it happens. When planning a step forward, it can be helpful to think about your most challenging patients, those with whom you have struggled or met resistance and how a PC-GOC approach might improve their care. It can also be helpful to think about examples of how you are already providing PC-GOC and how those processes and approaches could be expanded and enhanced.
3. **Doing** should almost never be postponed. New processes must be flexible enough to withstand unexpected occurrences (e.g., absence of a staff person due to illness or vacation).
4. **Studying** a new process requires deciding beforehand on what to measure. It is often necessary to measure performance both before and after the trial unless you are implementing a completely new process. When measuring performance at the end of a trial, it generally sufficient to review the experience with/of the last 10 qualified patients seen.
5. **Acting** may mean expanding the approach to a larger number of patients or clinicians, modifying it and trying it again with a small number of patients, or abandoning it altogether. The end of each PDSA cycle becomes the beginning of the next one. It is crucially important to **keep moving forward** regardless of obstacles and challenges.
6. Documenting each PDSA cycle can be a good way to keep the implementation moving forward and to serve as a reminder for later presentations and reports.

Hints:

1. Pick a small step that is relatively easy to implement. (The experience of success is important and contagious.)
2. Pick a single clinical team and a limited time frame or number of patients.
3. Decide on a performance measure that will indicate whether the step was successfully implemented. Decide whether it is necessary to assess performance prior to implementation of the step as well as afterward.
4. Assign someone to make sure the step is carried out as planned, measurement is completed, implementation problems are elucidated, the results are presented to the team in a timely manner, and the process is documented.

EXAMPLES:

Prevention of Premature Death

1. Estimate the number of annual prevention visits, the amount of time required, and the charges and reimbursement for all active patients over 2, 21, 45, and 65 under several different assumptions (AWV alone vs. AWV + level 5 visit vs. separate AWV and level 5 visit) and taking into account no-shows and cancellations.

2. Develop a "clinical pathway" for patients who have decided to undertake a key behavior change (e.g., smoking cessation, increasing physical activity levels, improving sleep). See Goal-Oriented Medical Care Appendix E for examples. Determine how it can be integrated into the care process and the record system.

3. Establish a consultation and referral relationship with one or more behavioral therapists with skills in motivational interviewing and cognitive behavioral therapy. For example, meet for lunch, discuss philosophies of care, and establish consultative and referral processes.

4. Develop a process for obtaining risk factor information for all patients prior to preventive care visits and for entering pertinent positives into the electronic record. Then test the process in consecutive patients scheduled for preventive visits to identify obstacles, challenges, and glitches. See Goal-Oriented Medical Care Appendix A for an example of a patient questionnaire.

5. Develop a method for spreading annual preventive visits evenly throughout the year (e.g., in the patients' month of birth), and identify challenges and develop mitigation strategies..

6. Create a plan for management of immunizations that maximizes efficiency, acceptance, and delivery (e.g., an immunization station, collaboration with local pharmacies, regular immunization clinics)

Maximization of Current Quality of Life

1. Establish a consultation and referral relationship with one or more physical and occupational therapists. For example, meet for lunch, discuss philosophies of care, and establish consultative and referral processes.

2. Develop a process for collecting information on functional needs, challenges, and aspirations and recording them in the electronic record. Test it on consecutive patients for one week.

3. Develop a process for collecting information on relationship needs, challenges, and aspirations and recording them in the electronic record. Test it on consecutive patients for one week.

4. Establish a habit of asking about and documenting daily activities and challenges and desired activities and values. Test it on consecutive patients for one week.

Optimization of growth and development

a. Evidence of efforts to support patient autonomy and competence

b. Recommendations and/or provision of additional sources of information

c. Documentation of efforts to prepare patients to manage reoccurrences and/or other future health events

d. Documentation of efforts to reframe health problems as challenges and/or opportunities

Ensuring a good death

a. Documentation of formal advance directives including designation of a surrogate decision-maker

b. Documentation of an informal discussion of end-of-life values and preferences including conditions considered worse than death

c. Evidence that end-of-life values and preferences have been discussed with potential surrogate decision-makers

d. Feedback from family members regarding the quality of end-of-life care provided/received following patients' deaths

B. Decide what to document, in what format, and who will be responsible for documentation of your implementation process and outcomes.

1. Documentation will obviously be important when measuring progress over time. Data can be displayed in tables or graphs. Run charts can be particularly helpful. Assign the documentation task to someone familiar with computer software that facilitates construction of the desired display(s).

2. Documentation can also be helpful when explaining your implementation to others within or outside of your organization. For that purpose, someone should be responsible for documenting the steps you take, the methods you tried, the challenges you faced, and the decisions you made (i.e., your plan-do-study-act cycles) across the entire project.

C. Schedule Debriefing Discussions

Shifting the focus from problem-solving to goal-achievement can be surprisingly difficult, particularly for physicians. It is so different from the way we were trained. It is therefore critically important to schedule regular (monthly or bimonthly) debriefing sessions in which the clinicians in the practice can reflect on and discuss the difficulties they are experiencing with this new way of thinking and practicing. For these sessions, an external consultant familiar with PC-GOC could be an ideal facilitator. Feel free to contact Dr. Mold for advice. His e-mail address is jameswmold@gmail.com.

Resources:

a. https://thenicl.com/the-importance-of-short-term-wins/

b. https://www3.pinkelephant.com/ressource/pinklink/na/issue145/Implementing-Quick-Wins-August-2013.pdf

APPENDIX 3

Hold an all-day practice retreat to create or fine tune your implementation plan.

a. Overview and discussion (approximately 45 minutes)

This can either be a quick review of the steps taken and progress made to date, or it could be a motivational presentation by an outside expert or experts.

b. Café conversations (approximately 1 1/2 hour)

A set of four 15- 20-minute small group discussions triggered by specific questions. The groups can be selected randomly and changed for different questions or selected groups could remain together throughout. If you decide to assign a facilitator to each table, they can use the prompt questions to help move the conversations in productive directions.

- Learn more at The World Café. © 2008 - Free to copy and distribute with acknowledgement: http://www.theworldcafe.com
- Do not have a Café Conversation until there has been an introduction to the concept across attendees to the Café.

Possible prompts for each round:

A. If the one and only goal of your practice was to help your patients stay alive for as long as possible up to the point at which they said to stop, what would you do differently than you are doing now? (Assume reasonable length of life metrics like estimated life expectancy, adequate reimbursement, and no governmental or regulatory constraints.)

Optional facilitator prompts:

1. Which preventive measures are likely to have the greatest impact?
2. Do you think you would have better results by offering all recommended preventive services or by individualizing recommendations based upon risk/impact assessments?
3. What additional processes would be needed to help people adopt healthier behaviors and what do you need to make this happen?
4. Would any additional team members be helpful?

B. If the one and only goal of your practice was to help your patients maximize their quality of life, what would you do differently than you are doing now? (Assume reasonable quality of life metrics, adequate reimbursement, and no governmental or regulatory constraints.)

Optional facilitator prompts:

1. How do you define quality of life? How do you think your patient may define their quality of life?

How do you know?

2. How would you determine what matters most to a particular patient?
3. What do you do now to make sure you are focusing on what matters most to patients?
4. Would any additional team members be helpful?

C. If the one and only goal of your practice was to help patients grow and develop into more capable, resilient, and adaptable human beings, what would you do differently than you are doing now? (Assume reasonable growth and development metrics, adequate reimbursement, and no governmental or regulatory constraints.)

Optional facilitator prompts:

1. How do you define resilience?
2. What can primary care clinicians do to help patients become more resilient?
3. What are you doing now to help patients become more resilient? How would your overall approach to patient care be different?
4. Would any additional team members be helpful?

D. If the one and only goal of your practice was to ensure that your patients experienced a good death at the end of their lives, what would you do differently than you are doing now? (Assume reasonable end-of-life metrics, adequate reimbursement, and no governmental or regulatory constraints.)

Optional facilitator prompts:

1. What is a good death?
2. Which patients should be included?
3. Are advance directives enough?
4. What are you doing now to make sure patients experience a good death? What else could you do?
5. Would any additional team members be helpful?

After the Café Conversation, review all materials and responses to identify patterns, important themes, and use this information to inform what first needs to be addressed culturally or operationally.

c. Break (15 minutes)

d. Brainstorming (approximately 45 minutes)

Review the ideas generated in the small groups, and then engage in a free-flowing discussion of the ways that a PC-GOC practice might look different from your current practice.

e. Lunch (approximately 1 hour)

f. Practice discussion #1 (approximately 1 hour followed by a 15-minute break)

Use the information gained and the ideas generated to improve your implementation plan, work on buy-in, improve understanding, accept change, develop work flows and decide on measures.

i. Components: Most practices will decide to implement processes and methods related to each goal category separately and sequentially. We recommend beginning with either the prevention goal or the quality-of-life goal. The processes needed to address the end-of-life goal can often be added to prevention processes. The growth development goal will probably be the most difficult one for most practices and should probably be tackled last.

ii. Sequence: Within each goal type, it is often helpful to first implement the processes that will be required to help individuals make and sustain behavior changes before beginning to identify the need for those behavior changes. For example, before asking about food insecurity, it would be wise to have established referral patterns to address it.

iii. Timeline: Experience suggests that you should allow at least two years for implementation, at least 6 months for each goal category. Further enhancements and full implementation is likely to continue for several additional years.

iv. External support (e.g., monthly tele-video calls to discuss progress and challenges)

g. Practice discussion #2 (1 hour)

Reach agreement on the kinds of measurable objectives you want to use to assess your current performance and to gauge progress throughout the implementation. Don't worry about the specific measure definitions, age ranges, or periodicity at this point. Those will be addressed in the Module 5.

Suggestions:

Prevention of premature death and disability

a. Risk assessment/analysis and prioritization

i. Risk factor questionnaires completed

ii. Wellness visits conducted

iii. Evidence of prioritization based upon risk profile, values, and preferences

b. High impact preventive services. Consider whether to measure assessment (e.g., assessment of current physical activity), strategies (e.g., encouragement to increase physical activity, YMCA membership), and/or objectives (e.g., increase in physical activity). We recommend tracking objectives whenever possible.

i. Physical activity

ii. Nutrition and hydration

iii. Sleep

iv. Shelter

v. Safety

vi. Toxins (cigarettes, alcohol, drugs)

c. Prevention of future disabilities

i. Efforts to protect sensory organs, brain, back, and/or joints

ii. Efforts to prevent, detect, and assist with addictions (food, shopping gambling, etc.)

Maximization of Quality of Life

a. Documentation of activities and relationships needed for day-to-day life.

b. Documentation of activities and relationships needed for a meaningful life

c. Documentation of desired (additional) activities that would make life more enjoyable and/or meaningful

d. Evidence linking plans of care to essential or meaningful activities and relationships

General

a. Adherence to scheduled follow-up appointments

b. Adherence to referral/consultative appointments

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